

that was associated with an absent right kidney. Semen analysis revealed oligospermia. We use 3 arms, and one additional port suction, total 4 incision. Transperitoneal approach right mullerian cyst of the vas deferens was resected.

**Results:** Operative time was 90 minutes. The procedure was technically accessible and minimal blood loss being less than 100cc and a drain was placed for 48 hours. The patient was discharged the next day and he is currently asymptomatic.

**Conclusions:** Minimally invasive robotic-assisted excision of a mullerian cyst of the vas deferens is technically feasible, and should be considered for the treatment of this rare condition.

#### VID-05.10

**Bulbar Artery Sparing During Reconstruction of Pelvic Fracture Urethral Distraction Defects (PFUDD)**  
Gomez Illanes R, Catalan G, Marchetti P  
Hospital Del Trabajador, Santiago, Chile

**Objective:** Reconstruction of pelvic fracture urethral distraction defects (PFUDD) requires mobilization of the bulbar urethra to reach the prostatic apex. To achieve this, the bulb of the spongiosum needs to be separated from the perineal body, with division of the bulbar arteries. The distal urethral stump then becomes a flap, with retrograde irrigation from the glans and some perforating arteries. However in some cases, penile arterial supply is compromised by the pelvic fracture, resulting in penile arterial insufficiency. In such cases, ischemic necrotic failure of the urethral reconstruction has been reported. In this video we demonstrate a technique to preserve arterial blood supply to the bulb.

**Patient and Methods:** A 23 year-old patient suffered a pelvic fracture after being struck by a bus, resulting in an extraperitoneal bladder rupture and a complete disruption of the posterior urethra. His bladder rupture was managed successfully with a suprapubic catheter and the urethra was reconstructed 4 weeks after injury. Surgical technique included traditional dissection of the bulb, but prior to its mobilization from the perineal body, the paired bulbar arteries were located using a hand-held Doppler ultrasound probe. In this case both bulbar arteries had good doppler signal; for surgical convenience, we elected to reflect the bulb to the left, and the right artery was divided to gain access to the deep perineum. The bulb was dissected and mobilized only from the right side, the scar was removed and the proximal prostatic

urethra was exposed as usual. No dissection was performed on the left side of the bulb to avoid injury to the left artery. The end-to-end anastomosis was then performed as usual. Preservation of bulbar arterial inflow coming from the left spared bulbar artery was proved by intraoperative Doppler ultrasound at the end of the procedure.

**Result:** Surgical time was 3 hours, and blood loss 150ml. After removing the urethral catheter the patient regained normal continent micturition. Erections were present prior and after the surgery. Follow up is 4 weeks at the time of submission.

**Conclusion:** Preservation of arterial blood supply to the bulb is desirable and feasible. To our knowledge, this technique has not been reported before; further studies and longer follow up are necessary to evaluate its benefits.

achieved by division of short urethral plate. Bulbar urethra is reconstructed using anterior vaginal wall flap and remaining part of divided urethral plate ventrally. Urethra is lengthened up to the tip of the glans using buccal mucosa graft and labia minora flap. The glans is incised in two parallel incisions and both glans wings are dissected extensively to enable glans closure without tension. The penile shaft is reconstructed using the remaining clitoral and surrounding genital skin. The labia majora are joined in midline to create the scrotum and two silicone testicle prostheses are inserted.

**Results:** Three months after surgery good esthetic and functional results were gained. Good voiding while standing is also achieved.

**Conclusion:** Metoidioplasty as a single stage procedure is a time-saving and safe procedure. It is recommended whenever the size of the clitoris is adequate to satisfy the patient's desire to void in standing position and to have masculine-like external genitals.

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#### Video Session 6: Reconstructive Urology, Incontinence MIS Tuesday, November 3, 15:15-16:55

##### VID-06.01

**Metoidioplasty as a One-Stage Gender Reassignment Surgery in Female-to-Male Transsexuals**

Djordjevic M<sup>1</sup>, Stanojevic D<sup>1</sup>, Bizic M<sup>1</sup>, Majstorovic M<sup>1</sup>, Kojovic V<sup>1</sup>, Martins F<sup>2</sup>, Pandey S<sup>3</sup>

<sup>1</sup>School of Medicine, University of Belgrade, Belgrade, Serbia; <sup>2</sup>Department of Urology, Pulido Valente Hospital, Lisbon, Portugal; <sup>3</sup>Kokilaben Institute and Research Center, Mumbai, India

**Introduction and Objectives:** Metoidioplasty is a technique for creating small penis out of hormonally hypertrophied clitoris that enables voiding while standing. We present one stage female to male gender reassignment surgery that involves vaginal removal, clitoral lengthening and straightening, urethral reconstruction and scrotoplasty with testicle prostheses implantation.

**Materials and Methods:** A 31-year-old female transsexual underwent sex reassignment surgery. Vaginectomy is done by complete removal of vaginal mucosa. Following the clitoral degloving, fundiform and suspensory ligaments are completely divided to lengthen the clitoris. Additional lengthening and straightening are

##### VID-06.02

**Muscle/Tunica Assisted Reconstruction in Complex Urethral Disease**

Patwardhan S, Sawant A, Ismail M, Bansal U, Varshney P

Department of Urology, Lokmanya Tilak Municipal General Hospital & Medical College, Mumbai, India

**Introduction and Objective:** Complex urethral disease is associated with altered penile and scrotal circulation and lost genital skin with multiple failed prior surgeries. Our objective was to evaluate gracilis muscle/tunica vaginalis as a graft bed and to evaluate buccal mucosa/preputial flap as a graft for neourethra in reconstruction of complex urethral disease.

**Material and Methods:** Four patients with complex urethral stricture (3 patients- redo end to end urethroplasty, 1 patient- multiple fistulas) were enrolled prospectively from September 2005 to May 2006. In 2 patients, gracilis muscle and in 2 patients tunica vaginalis (50% each) was used for the graft bed, on basis of excised callous tissue. For neourethra, in 1 patient preputial flap (25%), in 1 patient buccal mucosa (25%) and in 2 patients (50%) combined preputial flap and buccal mucosa was used.

**Results:** The mean age at presentation was 28.3 years. Mean length and breadth of Gracilis flap harvested was 11 cm and 6 cm respectively and of tunica vaginalis flap harvested was 13 cm. Mean harvest-